STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6009302	B. WING		08/05/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
SUNSET	HOME	418 WASH QUINCY, I	IINGTON ST L 62301	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
S 000	Initial Comments		S 000			
	Annual Statement of	of licensure violations				
S 9999	Final Observations		S9999			
	a) The facility shall procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory conformed and other policies shall complement of the written policies the facility and shall by this committee, and dated minutes and dated minutes and dated minutes and services to attain practicable physical well-being of the research resident's complan. Adequate and care and personal care needs of the reshall include, at a minute procedures: d) Pursuant to subs	dvisory physician or the ommittee, and representatives in services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed of the meeting. Seneral Requirements for hal Care provide the necessary care in or maintain the highest in or maintain the highest in accordance with a prehensive resident care properly supervised nursing eare shall be provided to each extend total nursing and personal esident. Restorative measures thinimum, the following ection (a), general nursing at a minimum, the following		Attachment A Statement of Licensure Vio	lations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 08/25/16

STATE FORM

6899

PRINTED: 09/19/2016 **FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6009302 08/05/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **418 WASHINGTON STREET SUNSET HOME QUINCY. IL 62301** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID. PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300,3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These requirements were not met as evidenced A. Based on record review and interview, the facility failed to to follow the Fall Policy and Gait Belt Policy requiring residents to have accessible call lights and safely transfer a resident to bed using a gait belt for one of seven residents (R19) reviewed for falls in the sample of 24. These failures resulted in R19 falling twice and sustaining a right elbow fracture and multiple lumbar spine fractures. B. Based on observation, interview, and record review, the facility failed to analyze resident falls for root cause, failed to implement effective fall interventions, failed to supervise a resident, failed to follow care plan fall interventions, and failed to

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A.

of 24.

Findings include:

identify side rail entrapment for one of seven residents (R10) reviewed for falls, in the sample

1. A Falls Management Program policy dated 7-8-16, documents, "In order to maintain a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(CONTRACTOR OF CALIFORNIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		IL6009302	B. WING		08/	05/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	1 001	00/2010
SUNSET	HOME		HINGTON ST IL 62301	REET		
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S9999	Continued From pa	ge 2	S9999			
	members are responsemoving, and reported fall checklist include call light, water pitcitems within arm's I R19's Minimum Da Section G Function documents R1 requone staff physical attransferring, and to 4-7-16 also documents R1's Transfer Care	vention program, all staff possible for seeking out, orting potential fall hazards. A ses that staff are to keep the her, glass, and any personal ength of the resident." Ita Set (MDS) Assessment al Status dated 4-7-16, uires extensive assistance of ssist for walking in the room, alleting. R19's MDS dated ents R19 is cognitively intact. Plan dated 1-7-16 to 6-24-16, uires extensive assistance of				
	transfers. R19's Incident Repedocuments "Reside on her right side aft Assistant) called a Care Plan dated 7-5 intervention on 5-5-leaving a call light was a side of the control of the c	er walker to ensure safety with ort dated 5-5-16 at 10:45 p.m., ort was found lying on the floor er a CNA (Certified Nursing nurse for help." R19's Fall 5-16, documents a post fall 16 of, "Educate staff about with a resident at all times s) are alone in their room."				
	signed by E2 (Direct documents, "On the approximately 11:00 ambulated with a round found (R19) on and bathroom with a member (E6/CNA) at the roller walker she assessment, (R19)	Report dated 5-6-16 and tor Of Nursing/DON), evening of 5-5-16 at p.m., (R19) was being oller walker to the bathroom. In the staff reported (R19) has slipped off e was sitting on. During the reported that her right arm ow, and the right elbow had a				

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		1L6009302	B. WING		08/	05/2016	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET AD			STATE, ZIP CODE			
SUNSET	HOME	418 WASH QUINCY, I	IINGTON ST L 62301	REET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
	mild discomfort and x-ray(R19) has a the right elbow and hospital for a splint. R19's right elbow x documents R19 has medial radial head. R19's written stater by E2 (Director of N reported that on 5-5 the bathroom. E6 pR19 and assisted F continued to comm ambulating wrong a the right manner. Swere almost to the needed to sit down me standing there i down the hall for an staff) got to the rood down" This sar reported that E6 did before (E6) left the E6's (CNA) Terminal documents, "Type of Failure to follow proresidents multiple tis several times how the manner. You (E6) of the resident when y results in a fracture This is a category to follow departmental On 8-2-16 at 10:30	6, (R19) still complained of d (R19) required a right elbow a fracture to the radial head of was transferred to the " -ray report dated 5-6-16, so a probable non-displaced fracture. ment dated 5-6-16 and signed dursing), documents R19 5-16 E6 (CNA) assisted R19 to but the roller walker in front of R19 up. R19 then stated, "(E6) ent to me that I was and I was not putting my feet in She (E6) really upset me. We bathroom and I told (E6) I. I was getting weak. (E6) left in the doorway and yelled nother staff. When they (other in I had already fallen me statement documents R19 d not leave a call light with R19 room. Action Report dated 5-9-15, of Warning: Termination. Decedures in transferring mes. You (E6) have been told transfer residents in a safe did not leave a call light with you left the room. This fall of the elbow to the resident. Wo offense with a failure to	S9999				

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2. The Facility's Gait Belt /Safe Handling Policy (undated) documents, "The policy of this facility is assure the safety of residents and employees during transfer and repositioning tasks. It is mandatory in this facility to use gait belts for the safety of residents and staff, therefore all licensed and certified nursing staff are to use gait belts while transferring residents. Disciplinary action will be taken with anyone not using a gait belt during a resident transfer."

was left without a communication device to call for help, got up without help, and fell. (R19) is alert and orientated, so it (the call light) would have helped prevent the fall and fracture....(E6) was termed because according to our policy and procedure, residents are to have call lights within

reach at all times."

R19's Fall Investigation Report dated 6-22-16 and signed by E2 (DON) documents, "On the evening of 6-21-16 at 10:00 p.m., (R19) was returning from the bathroom to the bed, ambulating with a wheeled walker and staff (E4/CNA). (E4) leaned forward to take (R19's) blankets down when (R19) fell on (R19's) buttocks to the floor. (R19) complained of right lower back pain....(R19) was sent to the hospital for evaluation...CT (Computed

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belt."

have kept hold of (R19) while pulling down the covers on the bed. This fall resulted in fractures to (R19's) back because (E4) let go of the gait

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		IL6009302	B. WING		08/0	5/2016
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	В.	* 1				
	documents the Incidiscuss the falls on about potential prevential	ment Program dated 7/8/13, dent Committee Team will a regular basis and confirm ventative fall measures and ize injuries from fallsThe of the Attending Physician, will interventions to reduce the ng recurs despite initial will implement additional or ns, or indicate why the current relevant.				
	(date unknown), do introduction of this pasphyxiation, entrap	dure for Safe Use of Bedrails cuments, "The aim of the policy is to help prevent death, pment, and serious injuries ate use of bed rails."				
	7/21/16, documents on 11/18/11 with the Mental Disorder, an The MDS dated 7/2 has severely impair extensive assistance	et (MDS) Assessment dated is R10 was originally admitted e diagnoses of Dementia, id Major Depressive Disorder. 1/16 also documents that R10 ed cognitive skills, requires e of two staff for bed mobility, te, and uses a trunk restraint				
	A Side Rail Assessn documents R10 use in bed.	nent dated 7/20/16, es bilateral half side rails when				
		Report dated 6/21/16 at 3:30 R10's) bed alarm was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	<u> </u>	IL6009302	B. WING		08/05	/2016
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
SUNSET	HOME	418 WASH QUINCY,	HINGTON STE IL 62301	REET		
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***	with (R10's) legs had beneath the side radated 6/21/16, docuposition while in beneath a side rail.	und lying face down on bed anging off and right arm il." A Physician Notification uments "(R10) rolled to prone d. (R10) got her arm pinned Large dark purple bruise to elbowBruise is 4.5 by 7.5				
	cause analysis for from 6/21/16. A Ca 6/21/16, documents placed while in bed device is properly p bedroom door ajar intervention dated 1 intervention for a se	rd does not document a root R10's fall and arm entrapment are Plan intervention dated adding a sensor pad to be for safety. Staff are to ensure laced and working and keep to monitor (R10). A Care Plan 10/7/15, indicates the same ensor pad had already been				
	lounge alone withou 9:45 a.m., 12:10 p.r room with the door not be visualized fro fall intervention indi	o the 6-21-16 fall. .m., R10 was in the 2nd floor of supervision. On 8/3/16 at m., and 1:28 p.m., R10 in her partly closed where R10 could om the hallway as the 6-21-16 cates. On 8-2-16 at 10:00 d half bilateral siderails.				
	stated there was no R10's 6/21/16 fall. R10's arm had not I	.m., E2 (Director of Nursing) further documentation on E2 stated the entrapment of been addressed and the side ved until the surveyor with E2 on 8/2/16.				
	9:00 p.m., documer blood present arour Assessed more and	ent Report dated 11/28/15 at hts "(R10) was on floor with hd head. (R10) was moaning. If noticed a small scrap to right right knee. 1.5 inch gash to				

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evening of 1/9/16.

dining room with no supervision and that R10's lap belt restraint was in place when last seen by staff." A Care Plan intervention dated 1/9/16, documents "When (R10) is anxious, place (R10) at nurses desk with staff." R10's medical record does not document R10 was anxious on the

On 8/4/16 at 9:18 a.m., E2 verified R10 fell on

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